City of San Diego
Progress Report to PS&NS Committee
By the Medical Marijuana Task Force
For October 16, 2002 Meeting

Dated: October 11, 2002
By: Chair, Juliana B. Humphrey

I. PROGRESS SUMMARY

Voluntary Verification Card Program Request for Proposal Process

As planned, the Voluntary Verification Card RFP was published in June 2002 with replies due by the end of July. After receiving and reviewing the submissions, a small committee met to discuss them on August 28, 2002. The committee decided to reject the submissions made based upon concerns regarding ability to perform the necessary functions of the contract as well as monetary issues. Further discussion yielded the opinion that (1) the City should obtain start up funds before reissuing the RFP; (2) the RFP needs to be directed to agencies that have a better understanding of the needs of the contract; and (3) non-profit agencies that regularly deal with patients likely to apply for the verification card would be ideal to supply this service.

Members of the Task Force are currently fine-tuning the RFP to enable respondents to more accurately prepare their proposals. It is anticipated that this RFP will be ready to publish in October with replies due in November. The goal of the Task Force is to select a provider by the end of the year and have verification cards ready to go early in 2003.

II. PROPOSAL

Possession and Cultivation Guidelines

Attached to this Report is a proposal from the Task Force entitled "City of San Diego Law Enforcement Guidelines Regarding Possession of Medicinal Cannabis." [*See* ***Attachment 1***.] These Guidelines represent the end product of much research, study and debate within the Task Force, with particular guidance from Dale Kelly Bankhead and the Legislative Subcommittee and StClair Adams and the Law Enforcement Subcommittee. As Chairperson Toni Atkins suggested during the June 19, 2002 report by the Task Force, we have actively sought input from the City Attorney, the San Diego Police Department, local physicians and patients, and the public, continuing the pattern of the Task Force's inclusive and exhaustive exploration of issues and options surrounding the implementation of the law.

Law enforcement guidelines are needed in our community. Contrary to the repeated assertions of the San Diego Police Department, patients, doctors and caregivers who have the legal right to avail themselves of the benefits of Prop. 215 are not doing so out of fear of reprisal from law enforcement. These law-abiding people are at a loss as to how to comply with the law and find no comfort in being told they are subject to a "case-by-case analysis." It is for the benefit of these residents -- a cancer patient who may never have tried marijuana before her diagnosis, a friend or family member of that patient that wants desperately to help alleviate her suffering, or a doctor who desires to learn more -- that the guidelines must be promulgated. The main goal of the Guidelines is to give notice to the community of the rights and responsibilities under the law and to provide a "safe harbor" for legitimate patients and their doctors and caregivers.

It bears repeating that Prop. 215 passed with a strong statewide majority which included the county of San Diego. [*See* ***Attachment 2***: Official Canvass on Prop. 215.] The community-at-large supports the medicinal use of marijuana. When respect for the vote of our citizens is shown by adopting the Law Enforcement Guidelines and creating a "safe harbor," the whole community benefits; respect for the law, and for enforcers of the law, cannot help but be enhanced.

The Task Force is not ignoring the conflict between our state law and federal law. Given the recent focus by the Drug Enforcement Agency on the seizure of patient cannabis gardens it is anticipated that there will soon be an answer to this dilemma in our courts. In the meantime, our California Attorney General still advises local jurisdictions to develop their own protocols regarding enforcement of Prop. 215, codified into California law as Health & Safety Code §11362.5. [*See* ***Attachment 3***: Text of Health & Safety Code §11362.5; and ***Attachment 4***: Memo by State Attorney General Bill Lockyer.] While the proposed guidelines do not, and cannot, resolve the state/federal clash, they can and do offer notice to local residents regarding the enforcement policies of the City of San Diego. However, in developing these guidelines, the Task Force reviewed current federal sentencing law in order to set threshold amounts of processed or cultivated cannabis below the mandatory minimum federal prison guidelines. [*See* ***Attachment 5***: 21 United States Code § 841 at pp. 2 - 3.]

The following is a synopsis of the terms of the Guidelines with supporting documentation and, where appropriate, an explanation of how or why a particular term was chosen. The Task Force is pleased to answer any questions regarding the guidelines or our process in advance of or at the October 16, 2002 PS&NS meeting.

A. Part I: Introduction

The goals of the Guidelines are set forth in the opening paragraphs of Part I. The fear

surrounding the issue of arrest and seizure of medicinal cannabis are addressed first: no one who qualifies under these guidelines will be arrested, nor will their cannabis be

seized or destroyed. This statement is followed by a strong caveat which deserves quotation:

> *Nothing in these guidelines is intended to shield anyone who is breaking the law, nor are these guidelines intended to abrogate or expand any rights created by state law.*

This statement of purpose was written with the aid of law enforcement advisory members as well as the Task Force itself in an effort to be clear with our community that while the City is striving to implement the law, it will not protect those who seek to abuse the law.

The introduction also makes clear that there may be some patients for whom the "safe harbor" amount of cannabis provides too little for their illness. [*See* ***Attachment 6***: Cannabis Amounts Provided to IND Patients by U.S. Govt.] Such patients can still receive a Voluntary Verification Card but will be evaluated by the San Diego Police Department on a "case-by-case basis" under Section II of the guidelines.

B. Status as Patient or Caregiver

An integral part of the "safe harbor" guidelines is possession of a Voluntary Verification Card which law enforcement may use to verify a person's status as a patient or caregiver any time of the day or night. Therefore, the card is a prerequisite to coverage under the guidelines. [*See* ***Attachment 7***: Voluntary Verification Card Ordinance.]

The definition of primary caregiver was discussed at length during Task Force meetings and within the subcommittees. SDPD representatives had no written definition of "primary caregiver," but believed that it meant a person who was responsible for "housing, health and safety" of their patients. After discussing the disjunctive nature of the law ("housing, health or safety") law enforcement represented that SDPD's interpretation of the law would still include only persons who had primary responsibility for the patient's health needs. Patients informed the Task Force that people who cared for their medical needs were unwilling, or in the case of persons under contract to a hospital or medical group, unable to provide cannabis to them. They had no way to obtain this medicine without help. Without the ability for these patients to seek out help from someone to obtain cannabis, the law would have no meaning.

The only published legal precedent on this issue, *People ex rel. Lungren v. Peron (*1997) 59 Cal. App. 4th 1383, recognized this conundrum. The Court of Appeal noted at page 1400: "A primary caregiver who *consistently* grows and supplies physician-approved or prescribed medicinal marijuana for a section 11362.5 patient is serving a health need of the patient[.]" [*See* ***Attachment 8***: Full Text of the *Peron* case.] It is more logical that a patient would seek out a family member, friend or person known to be able to help for assistance with obtaining cannabis than to obtain it from a nurse, social worker or other

person whose job it is to assist the patient. Under *Peron*, if their relationship is consistent, it is lawful. [*See* ***Attachment 9***: Legal Memorandum re: Federal Status; Definition of Caregiver.]

The *Peron* Court also held that a person could be a caregiver for more than one person, provided that the caregiver "consistently provides" for the patients needs. (*Peron* at p. 1399.) Our Voluntary Verification Card Ordinance limits caregivers to no more than 12 patients. The Court also held that a caregiver could "seek reimbursement for such services." (*Peron* at p. 1400.)

C. Amount of Cannabis

There were no topics that garnered more discussion and debate than the determination of the dosage amount of cannabis required for medicinal use, how much cannabis a patient could possess at any given time, and the numbers of plants and planting area to be approved for cultivation. The Task Force was diligent in seeking information on this issue from doctors, patients, published research, and other jurisdictions in California, as well as listening to community input regarding issues specific to San Diego.

It must be remembered that when a patient needs medical cannabis the big unanswered question remains, "where do I get it?" It would be terrific if a patient could simply go to a pharmacy and be provided with a safe and consistent supply of cannabis – but this is not the case. Since patients cannot go to a pharmacy their choices are to either engage in a risky black market transaction with a criminal or grow their own, either alone or with a caregiver. Many feel that the government should step in to provide safe medical cannabis to qualified residents – a step taken in solidarity with DEA raided patients by government officials in Santa Cruz during a one-day giveaway; and a bold ballot measure proposed in San Francisco where, if passed, the city would become the provider of medical cannabis. The Task Force determined that for our community the most practical approach is to establish realistic guidelines that enable patients and their caregivers to grow enough to meet most needs while still protecting community safety.

Another aspect of not being able to simply purchase cannabis at a pharmacy is that patients need to keep more than a typical one month's supply of their medicine. As will be explained below, persons who grow cannabis outdoors can only do so one time per year; thus, they need to grow a full year's supply at one time – up to three pounds under the guidelines. This amount has concerned some members of the community but if compared to other medications used to combat symptoms similar to those treated by cannabis, the numbers of pills needed for an entire year are very substantial and place the amount of cannabis in context. Three pounds of cannabis (able to be stored in an area approximately the size of two shoe boxes) looks quite similar in volume when compared, for example, to an annual dose of 4,380 to 8,760 Vicodin or Percodan pills

for pain management. The difference is the availability of one medication on a monthly basis, and not the other.

First and foremost, the consensus of the Task Force was that, because this is a medical issue, physicians who make the recommendation for cannabis on behalf of a patient should specify, as much as possible, the dosage amount or dosage range. Thereafter, the amount of cannabis possessed or cultivated by a patient or by his/her caregiver must correlate to the amount suggested by a physician as an appropriate dose for the condition being treated. Based upon a poll of physicians in the community, the Task Force believes that sufficient numbers of doctors in our community will be willing to learn more about marijuana as medicine and to assist patients with this issue. [*See* ***Attachment 10***: Survey of San Diego Physicians regarding Prop. 215 and the Use of Medical Marijuana].

Despite the clear interest expressed by the doctors responding to the Task Force's survey, there will remain some in the community who will resist stating dosage amounts for fear of adversely affecting their licenses. So far federal courts have ruled in favor of doctors speaking with their patients about medical cannabis, but the question is currently on appeal in the 9th Circuit. The Task Force encourages the City to continue our efforts at educating physicians on this subject, urging them to keep the issue of medical cannabis within the realm of medicine by making dosage recommendations.

Physician input was also an important issue for the law enforcement representatives from SDPD who attended the law enforcement subcommittee meetings on this issue. While they maintained the department's overall reluctance to provide specific guidance, they said they would be "much more comfortable" if the guidelines were based on individualized medical advice not a one-size-fits-all formula. The police representatives felt that physician input about dosage gave them an added measure of confidence in the amount of medicinal cannabis patients claimed they needed to possess or grow.

To create a "safe harbor" which reflected the state of medicine in San Diego, the Task Force sought information from local doctors treating patients who use medicinal cannabis. What emerged was an average dosage amount of one gram per cannabis cigarette ("joint") and from three to five joints per day depending on symptoms. Some patients used less (7 grams per week) while some patients used more (14 grams per day). [*See* ***Attachment 11***: Table of Sample Physician's Statements with recommended doses.] Understanding that no "guideline" can cover every patient's needs, the goal of the Task Force was to reach a middle ground that would serve the needs of *most* patients in our city.

The local anecdotal dosage information conformed with the dosage amounts published in medical research studies wherein cannabis was provided to patients on an experimental basis for various illnesses and symptoms. [*See* ***Attachment 12***: Sample Bibliographies of Research Studies.] For example, in a recent study conducted by Dr. Donald I. Abrams of the University of California San Francisco entitled "Short-term Effects of Cannabinoids in

HIV Infection," users of smoked THC (cannabis) generally smoked daily and used up to 3 joints per day, each joint weighing one gram. This study, consistent with other studies, noted that patients tend to use only the amount needed to quell the symptom(s) at issue; that is they may not smoke the entire "dosage" amount of an entire one gram joint, but smoke only as much as needed to obtain relief.

From an average dosage amount of three to five grams per day, the Task Force calculated the annual amount needed for an average patient in the following manner:

3 grams x 365 days/year = 1095 grams ÷ 28 grams/ounce
= 39.11 ounces ÷ 16 ounces/pound = 2.44 lb

5 grams x 365 days/year = 1825 gm ÷ 28 grams/ounce
= 65.18 ounces ÷ 16 ounces/pound = 4.07 pounds

Rounding down the average of the two amounts (3.25 lb) provides a basis for the recommended guideline amount of three pounds. But we did not make this decision solely based on the average dosage amount within our community or from medical studies. The Task Force researched and evaluated the findings of other jurisdiction in our state.

Attached to this memorandum is a list of cities and counties in California that have adopted guidelines for medical cannabis and details regarding each jurisdiction's guidelines. [*See* ***Attachment 13***: Table of California Guidelines by Jurisdictions.] From Arcata to Yuba County, communities have gone through the process of selecting among reasonable choices to develop the standards which best reflect their local values. The proposed guidelines for San Diego most resemble those passed in the City of Oakland. That city went through an enormous amount of public debate, debate which included cutting their possession guidelines in half (from six pounds to three pounds). In the end, Oakland's guidelines appeared to the Task Force to be well thought out and supported by reliable information, particularly with regard to expected yields from cultivation. Since Oakland finalized their guidelines, the counties of Sonoma and Tehema have followed suit allowing up to a maximum of three pounds processed cannabis per patient.

Oakland relied on cultivation yield information published by the Drug Enforcement Administration in 1992 (hereafter "DEA"), as well as information from other interested persons with expertise in the area of cultivation. Issues regarding cultivation are complex with many facets that affect cannabis yields. For example, if plants are placed closer together, the yield of usable plant material (leaf and flower bud) decreases. Plants grown indoors are generally smaller than those grown outdoors, decreasing yield. On the other hand, one may grow three or four crops of cannabis indoors

whereas there is only one outdoor growing season (April to October) where a grower must harvest a full year's supply of cannabis.

Growers must also consider the sex of the plants. During the 30 to 90 day vegetative stage the plants are sexually undifferentiated. The second stage is the flowering or fruiting stage where the plants can be identified as "male" or "female". Only female plants produce buds which contain the highest medicine content and seed for the next crop. Male plants have no buds and are generally removed by the grower after they pollinate the female plants. If they are kept in the garden, the male plants are generally half the size of female plants. [*See* ***Attachment 14***: DEA Guidelines, at pages 8 and 9.]

After the Task Force heard information regarding all of these issues, and analyzed how other jurisdictions dealt with the above variables, it voted on the grow areas and plant numbers in the guidelines. Again, these guidelines are intended to meet most patients' needs whether cultivation occurs indoors or outside. In San Diego, where sun is plentiful and free, it should be anticipated that many patients may avail themselves of outdoor cultivation.

The Task Force was not entirely comfortable with the DEA's 1992 yield estimate of over 200 grams per plant. Patients and caregivers reported yields far less than that, and opined that perfect growing conditions as well as a wealth of knowledge and ability on the part of the grower would be required to approach such a yield. The reality is that cannabis is not an easy plant to grow in the first instance and is susceptible to all the pitfalls affecting any garden plant: insect infestation, disease, and crop failure. In addition, many who grow the plant do so for the first time and may not have a "green thumb." (Patients who live in apartments may not be able to grow outdoors at all and will need to buy equipment to grow indoors, or seek out a caregiver.)

The Chair of the Task Force looked to the 2002 Federal Sentencing Guidelines to see if there existed a standard average weight designated for cannabis plants in federal court. According to the latest version of these guidelines, in cultivation cases courts are to "treat each plant, regardless of sex, as equivalent to 100G of marihuana" unless the actual weight is greater. The commentary regarding this section states that the Commission "adopted an equivalency of 100 grams per plant" based on "the fact that the average yield from a mature marihuana plant equals 100 grams of marihuana." [*See* ***Attachment 15***: Federal Sentencing Guidelines Manual, § 2D1.1; relevant sections highlighted at pages 8 and 16.]

Using the 100 grams per plant yield and the metric conversion figures from above:

3 pounds cannabis per year = 1344 grams = 13.44 plants

The Task Force decided that consideration must be given to the sex of the plants and the vagaries of growing outdoors in deciding the maximum number of plants for an outdoor

garden should be 20.

It was explained at several Task Force meetings that indoor plants yield far less cannabis than outdoor plants (the DEA study involved only outdoor growing conditions.) The Task Force followed Oakland's lead of limiting indoor gardens to 72 plants.

However, when considering the numbers of plants caregivers may grow on behalf of patients, the Task Force parted ways with Oakland and took a more conservative path. In Oakland, they simply multiply the amounts individual patients are allowed to possess or cultivate by the number of patients per caregiver. Thus, an Oakland caregiver with 10 patients could have 30 pounds of cannabis or grow 200 plants growing outdoors. Since this result seemed unreasonable for our community, the Task Force capped both the possession and cultivation amounts at 12 pounds and 90 plants respectively.

First, it was important to the Task Force not to recommend to the City of San Diego guidelines that ran afoul of federal "minimum mandatory" sentencing guidelines. While patients and caregivers must have their eyes wide open regarding the potential federal criminal penalties attached to possession and cultivation of cannabis, we did not want anyone following the city's guidelines to be facing mandatory prison should they become a test case. The amounts chosen fall below mandatory prison guidelines. [*See* ***Attachment 5***: 21 United States Code § 841 at pp. 2 - 3.]

But a second, equally important consideration affected the Task Force: consideration of the quality of life in our neighborhoods. Guidelines regarding cannabis yield, by themselves, do not answer questions regarding the quality of life in our neighborhoods, or "how much is too much?" We did not want to publish guidelines that, in essence, created public nuisances or invited criminal activity. While the guidelines require outdoor growing spaces to be "enclosed and secured," it was acknowledged that neighbors would not be happy with a huge cannabis garden next door regardless of its enclosure or security. Thus, while making sure patients' medical needs were taken care of, the need for peaceful coexistence in neighborhoods was also a priority.

To that end, the Task Force next considered suggestions for outdoor growing areas up to 800 square feet, and indoor areas of up to 400 square feet. By the final vote, choices were made to satisfy patient needs and neighborhood safety concerns: 100 square feet for outdoor cultivation and 125 square feet indoor cultivation. For caregivers growing for others, the square footage remains constant regardless of the number of patients.

D. <u>Compliance with Smoking Laws</u>

At the present time the smoked form of cannabis gives the majority of patients the most immediate relief for many commonly treated symptoms: nausea, inter-ocular pressure, appetite loss, chronic pain, and migraine onset. The patient is able to regulate the

medicine so as to take only the amount needed at that moment – a puff or two – as opposed to ingesting a set amount which may provide too much or too little medicine to treat the particular symptom.

The Task Force felt that patients who need their medicine and who are away from their homes should be allowed to take it – whether by smoking or ingesting. However, the consensus was that patients should use common sense and discretion when using medicine in a public area. Therefore the Task Force added the rule that patients needing to smoke in public must abide by rules governing tobacco smoke. In addition, the text of H&S §11362.5(b)(1)(C)(2) includes the mandate that patients cannot engage in "conduct that endangers others." This section clearly permits law enforcement intervention to stop the use of medical cannabis around minors or where second hand smoke is endangering others.

E. Guidelines for Persons Not Meeting the "Safe Harbor" Conditions

Where a patient or caregiver chooses not to obtain a Voluntary Verification Card or to follow the City's guidelines, the police will simply handle their investigation of possession or cultivation of cannabis by a person invoking H&S §11362.5 as they do now: on a "case-by-case" basis. As stated on page four: "Nothing in the guidelines is intended to reduce or expand the rights of a patient or primary caregiver otherwise authorized by Health and Safety Code §11362.5(d)."

The Task Force added a 72 hour "waiting period" prior to seizing live plants which applies to all persons who invoke H&S §11362.5. It was reported time and again that persons whose plants were seized, and who were ultimately found to be qualified medical cannabis users, were irreparably harmed by the permanent loss of their medicine. Particularly where the patient grows outdoors, there is no opportunity to begin a new garden for a year. Unlike other items law enforcement may seize from a home, live plants cannot be returned to a person "status quo." Thus the Task Force felt some investigation time was needed to make certain that the permanent seizure of cannabis plants was appropriate and necessary. However, the guidelines make clear that police may immediately seize cannabis plants (or processed cannabis) in excess of the "safe harbor" amounts. Again, law enforcement representatives participated in the discussion of this item without agreeing to specifics. Representatives did state that 72 hours should generally be sufficient to investigate a medical cannabis claim.

F. Caregiver Code of Conduct

The Task Force added the "Caregiver Code of Conduct" to emphasize the responsibilities that caregivers must recognize and accept when assisting patients with medical cannabis. The Code is intended to minimize the opportunity for non-medical cannabis use and other nuisance or criminal behavior. The Task Force believes that

the City has the right to expect caregivers who wish to avail themselves of the "safe harbor" will follow the Code of Conduct.

CONCLUSION

The "Compassionate Use Act", better known as Prop. 215, was enacted by a clear majority of Californians in 1996 and remains the law. Patients, after consultation with their physicians, are permitted to use cannabis. This is not the forum for debate on the utility of cannabis as medicine, marijuana abuse in teens, or drug legalization. The issue squarely before this council is whether to leave the implementation of the law to the murky "case-by-case" analysis of law enforcement, or to take the lead in providing notice and guidance to patients, doctors, caregivers, and law enforcement.

Upon the enactment of these guidelines the next step is pubic education on the issue of medical cannabis: education of patients, doctors, caregivers, law enforcement and the public. The Task Force has already begun this process by creating a medical cannabis information area on the city's website and stands ready to continue assisting the city with its future educational endeavors. By shedding light – and accurate information – on the relevant issues, San Diego can join other California cities and counties in providing true leadership in the area of medical cannabis.

These guidelines represent many hours of thought, research and writing by Task Force members as well as input and critique by law enforcement, the City Attorney's office, and diverse members of the public. From the creation of the Task Force, our goal has always been fair implementation of the law for the benefit of patients, doctors, caregivers, and the community. These guidelines give notice to everyone in the community what the rights and responsibilities are for those who seek to avail themselves of medical cannabis. They encourage understanding and discourage disrespect for the law. We strongly urge this committee to consider and approve these guidelines for the benefit of all residents of the City of San Diego.